PSYCHOLOGICAL CASE RECORD

Submitted to the Tamil Nadu Dr. M.G.R. Medical University in part fulfillment of the requirements for the Diploma in Psychological Medicine Examination 2008

By

Dr. DEEPTI KUKREJA

ACKNOWLEDGEMENTS

I am very much indebted to Mrs. Sushila Russell, Lecturer in Clinical Psychology, Department of Psychiatry, for their valuable guidance and supervision.

I express my gratitude to Dr. Prathap Tharyan, Dr.K.S.Jacob and Dr.Paul Russell for allowing me to administer tests to the patients under their care.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr.Deepti Kukreja** during the year 2006-2008. I also certify that this record is an independent work done by the candidate under my supervision.

Dr. K.S.JACOB

Professor and Head

Department of Psychiatry

Christian Medical College

Vellore 632 002.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Deepti Kukreja** during the year 2006-2008. I also certify that this record is an independent work done by the candidate under my supervision.

Mrs. Sushila Russell, M.Phil,

Lecturer in Clinical Psychology

Department of Psychiatry

Christian Medical College

Vellore 632 002.

CONTENTS

ACKNOWLEDGEMENTS

I am very much indebted to Mrs. Sushila Russell, Lecturer in Clinical Psychology, Department of Psychiatry , for her valuable guidance and supervision.

I express my gratitude to Dr. Prathap Tharyan, Dr. K.S.Jacob and Dr. Paul S.S.Russell for allowing me to administer tests to patients under their care.

I would like to express my sincere thanks to all the patients and their families who kindly cooperated with me even though they themselves were in agony.

DEEPTI KUKREJA
CHRISTIAN MEDICAL COLLEGE
VELLORE

CASE RECORD

NAME	: M.S.
AGE	: 13 YEARS
SEX	: FEMALE
MARITAL STATUS	: SINGLE
OCCUPATION	: STUDENT (7^{TH} STD)
SOCIO-ECONOMIC STATUS	: MIDDLE
RELIGION	: HINDU
PLACE	: BANGLADESH
INFORMANTS	: PARENTS
RELIABILITY	: RELIABLE, COMPLETE.

CHIEF COMPLAINTS

Pain in both legs, extending from toes till mid thighs associated with inability to walk.
Refusal to go to school.

DURATION
3 years, increased for last 7 months.

MODE OF ONSET
Gradual.

PRECIPITATING FACTOR
Nil significant .

HISTORY OF PRESENTING ILLNESS

Ms. M.S. presented with a 3 year history of refusing to go to school. Her performance started deteriorating and attendance started falling to below 20%. She started having less interaction with her family and friends. For the last 7 months she started complaining of pain in her feet starting from her toes and gradually progressing proximally. She stopped going to school altogether and started having crying spells frequently. She had been extensively evaluated by various specialists and no medical cause was found for the symptoms and hence she was referred to Child Psychiatry.

PAST HISTORY

She had no past history of any medical or neurological illness.

FAMILY HISTORY

The patient was born of nonconsanguinous marriage. She was the 2nd born of 3 siblings. Parental control was fair but the parents' emotional relation with all 3 children was poor, especially the mother's. There was no family history of neuropsychiatric morbidity.

BIRTH AND DEVELOPMENT HISTORY

She was born of a normal vaginal delivery in hospital, cried at birth and was of average size. Her developmental milestones were normal. She was described as an anxious child, very subdued, under assertive in her dealings with her siblings and friends. She was passive and would not fight back. She was described as an average student, poor in English and strong in Mathematics. However from 4th standard she started refusing to go to school and her performance started deteriorating gradually.

PHYSICAL STATUS

Her vital signs were stable. There were no focal neurological deficits. Other systems were normal. She was unable to walk due to pain in both lower limbs.

MENTAL STATUS EXAMINATION

She was thinly built and well kempt. She was cooperative towards the examiner. Her speech was very soft but relevant and coherent. She had delayed reaction time to certain questions. She was oriented to time, place and person and her memory was intact. Her thought process did not reveal any abnormality. She denied any perceptual abnormality. There were no compulsive phenomenons or volitional abnormalities. Her reading skills were inadequate, with many omissions and writing revealed spelling mistakes. Her insight into the illness was poor and her judgment was intact.

DIFFERENTIAL DIAGNOSIS

Mood Disorder

Persistent Somatoform Pain Disorder

Adjustment Disorder

AIM FOR PSYCHOLOGICAL TESTING:

To rule out underlying mood disorder

To determine areas of conflicts and stressors.

To assess her personality and intellectual functioning.

TESTS ADMINISTERED AND RATIONALE FOR THE SAME

1) Binet Kamat Test (BKT) was used to assess her intellectual level.
2) Vineland Social Maturity Scale (VSMS) was used to measure the differential social capacities.
3) Bender Gestalt Test (BGT) was used to rule out any organic causes for her problems.
4) Draw A Person Test (DAPT) was used as a projective test that has been found useful in providing an understanding of the patient's personality as well as in ascertaining any psychopathology.
5) Kinetic Family Drawing Test was used to assess the family's dynamics and the patient's perception of her family.
6) Controlled Projection Test (CPT) was used to assess any underlying conflicts.
7) Thematic Apperception Test (TAT) was used to assess underlying unconscious conflicts and stressors.
8) Children's Personality Questionnaire (CPQ) was used to assess her personality.

GENERAL OBSERVATION

The patient was cooperative and interested, however her comprehension of instructions was not good. She was not very alert. She was very worried about doing the correct thing therefore took very long. She was contemplative and kept correcting herself numerous times. She was more interested in drawing and play than arithmetic and projective tests. She was quite anxious and needed approval from therapist about quality of work.

Her attention and concentration is good. Her memory and motivation was also good. She is persistent in her efforts.

However her planning and organisational skills are fair.

TEST FINDINGS

INTELLIGENCE TESTS:

BKT showed mental age of 10 years indicating. Her chronological age is 12 yr 7 months, her mental age is 10 years and her I.Q is 80 indicating borderline intelligence.

Her language skills are good. Her conceptual thinking, arithmetic reasoning and verbal reasoning skills are below her age level. Her visuomotor and social intelligence much below her age level.

VSMS – the profile on various dimensions were as follows:

Self help general	: 7.28 years
Self help dressing	: 12.30 years
Self help eating	: 9.63 years
Communication	: 10.30 years
Self direction	: 9.38 years
Socialization	: 8.28 years
Locomotion	: nil
Occupation	: 11.25 years
Total	: 12 years 5 months (without locomotion)
	: 8.85 years if locomotion is included.

WISC was not done, keeping her cultural background in mind.

Specific Learning Disability Screening

She could read a simple passage and her reading comprehension was fair. On dictation spelling mistakes were present but not significant, omissions of certain letters which are not sounded was present. Her handwriting was fair, however her reading and writing skills were below the expected level for her age.

Further testing was not done as there was global delay in academic skills and there were no specific features suggestive of Specific learning disability.

Personality

She is a reserved and restrained person who is easily upset due to social factors. She is quite inactive, submissive and conforming. Also she

is serious, contemplative and conscientious. She is very sensitive, fearful and socially controlled. She is apprehensive and worries a lot.

She likes to project herself in favorable light and has high aspirations, but is unable to cope due to her intellectual compromise. Therefore has low self-esteem and confidence.

Her family relationships are not well-defined…she sees her mother as a teacher and father as a provider…unable to associate with them emotionally. Boundaries between different units within the family are not clear.

She doesn't have very good interpersonal relationships, either within the family or with peers.

She doesn't express her needs to her family, either material or emotional……and she feels her worth is only w.r.t her academic performance.

IMPRESSION

The test findings are suggestive of an introverted person who is underassertive and reserved. She has significant conflicts in her family relationships. She lacks adequate coping skills. Also she has borderline intelligence which may be contributing to her school refusal and somatic complaints. There was no indication of an underlying mood disorder.

With the above testing we could rule out a mood disorder and adjustment disorder.

DIAGNOSIS

Persistent Somatoform Pain Disorder
Borderline Intelligence

MANAGEMENT

The patient and the family was psychoeducated about the illness. Behavior therapy was started for symptom removal. Reward system was started for desired behaviors. Differential reinforcement was also used. Psychosocial issues, parental emotional attachment with the children were also addressed. Problem solving skills and coping techniques were taught. A step down in curriculum and alternative schooling system was suggested.

CASE RECORD

NAME	: P. N.
AGE	: 16 YEARS
SEX	: FEMALE
MARITAL STATUS	: SINGLE
OCCUPATION	: STUDENT
RELIGION	: HINDU
INFORMANTS	: PARENTS, SISTER
RELIABILITY	: RELIABLE, COMPLETE.

CHIEF COMPLAINTS

Multiple episodes of unawareness
Multiple somatic complaints
Adamant behavior

DURATION

Since childhood, episodes of unawareness since last 1 ½ months

PRECIPITATING FACTOR

The teacher passed a remark about her work and awarded her less marks than a classmate.

HISTORY OF PRESENTING ILLNESS

The patient is premorbidly described as a very adamant child, very short tempered. She presented with a 11/2 month history of sudden episodes of severe headache followed by stomache and then becoming unaware of her surroundings. Following this she has some altered behavior like shouting and abusing which settles immediately on taking a painkiller. This was precipitated by her Mathematics teacher making a remark about her work and giving her less marks on a project compared to a classmate. Recently the episodes would occur even on the slightest remark form her parents, teachers or friends. She was noticed to be more irritable, demanding of time and attention from her family, teachers and friends.

PAST HISTORY

There was no past history of any neuropsychiatric morbidity.

FAMILY HISTORY

She is born of a nonconsanguinous marriage and she is the second born of two children. There is no family history of neuropsychiatric morbidity.

PERSONAL HISTORY

The patient was born of normal vaginal delivery. Her birth weight was 2.5 kgs. She cried immediately after birth. She had no post natal complications. Her developmental milestones were normal. She had been an average student at school and currently doing her 10^{th} standard. She has few friends, all girls of similar age. She finds it difficult to maintain her friendships because of her short temper and argumentative nature. She is interested in dance, cultural activities and watching TV. She is very close to her elder sister.

TEMPERAMENT

She was described as a child with difficult temperament. She was extremely demanding and if her demands were not fulfilled she would have temper tantrums. She was able to relate well with her family members.

PHYSICAL EXAMINATION

Her vital signs were stable. She had no focal neurological deficits. Other system examination was normal.

MENTAL STATUS EXAMINATION

She was thinly built, well kempt, and adequately dressed. She was cooperative but anxious. She was alert and maintained good eye contact. She was oriented to time, place and person. Her memory was intact. Her speech was audible, coherent and relevant. Her reaction time was normal and vocabulary was good. Her thought process did not reveal any abnormalities. She denied any perceptual abnormalities. Her affect was cheerful and reactivity was good. She was of average intelligence. Her insight was grade V and judgment was intact.

AIM OF PSYCHOLOGICAL TESTING

The aim of psychological testing was to enable us to explore her unconscious conflicts and to assess how her personality traits were contributing to her present problems.

TESTS ADMINISTERED

Eysenck's Series of digit Span Test (ESDST)
Bender Gestalt Test (BGT)

Sack's Sentence Completion Test (SSCT)
Modified Jalowie Coping Scale
Bell's Adjustment Inventory

RATIONALE OF THE TESTS

1) Eysenck's Series of Digit Span Test (ESDST)

This test is administered in order to find out the level of attention and the ability of the patient to sustain her attention span. For undergoing the psychological tests, an optimum level of attention and concentration is required.

2) Bender Gestalt Test (BGT)

In order to rule out any organic cause of the problem and to differentiate functional illness from organic illness, BGT is used. It also assesses the person's visuo-motor coordination.

3) Sack's Sentence Completion Test (SSCT)

For assessing the conflict areas in the patient, SSCT is used.

4) Modified Jalowiec Coping Scale

For identifying the person's ways of coping with various situations.

5) Bell's Adjustment Inventory

This is used to understand a person's personality traits. It was used to try to find out the dynamics of the patient's personality.

TEST FINDINGS

Her attention and concentration was good. The BGT did not reveal any organicity or visuo-motor incoordination.

The SSCT revealed poor communication with her father, poor self-esteem, need for attention from peers, high degree of attention seeking behavior. She tends to exaggerate her thoughts and feelings, making things sound more important than they really are. Her relationships seem to be superficial.

The Modified Jalowiec Coping Scale revealed predominantly evasive style of coping with issues. She seems to get worried a lot. Also she needs external support to sort out problems.

Bell's Adjustment Inventory showed low self-esteem, feelings of inadequacy, need for attention, strong need for dependency. She seems to be self-absorbed, superficial and fickle-minded. There were some conflicts in the sexual area. She seemed unaware of her true feelings and cannot explain her true motivations.

She has inadequate stress tolerance and coping resources. Her self-image is negative.

IMPRESSION

The individual is emotionally less stable and has inadequate use of personal coping resources. She shows a high degree of attention seeking behavior. She tends to be over sensitive of criticism. She is impulsive and emotionally unstable. She has excessive need for reassurance and acceptance from her family and peers. She has strong dependence needs which makes her overly trusting and gullible.

DIAGNOSIS

Dissociative Motor Disorder
Histrionic Personality Traits

MANAGEMENT

She was started on cognitive behavior therapy. Coping skills and problem solving skills were addressed. Assertiveness training was given. Simultaneously family assessment was done to assess areas of conflict and family therapy was initiated.

CASE RECORD

NAME	: B.K.
AGE	: 7 YEARS
SEX	: FEMALE
EDUCATION	: SPECIAL SCHOOLING
SOCIO-ECONOMIC STATUS	: LOWER
RELIGION	: HINDU
INFORMANTS	: PARENTS
RELIABILITY	: GOOD

CHIEF COMPLAINTS

- Delayed milestones
- Seizures since 8 months of age

HISTORY OF PRESENTING COMPLAINTS

She has had delayed developmental milestones since birth. Currently she does not talk and has no self care skills. She does not communicate her needs and is fully dependent for self care activities.
She started having generalized tonic clonic seizures since 8 months of age and has been on anti epileptic drugs since the past 4 months only. The seizures have continued , her last episode of seizure was 5 days ago. There was no history suggestive of any psychiatric morbidity.

FAMILY HISTORY

The patient is born of consanguineous marriage, 3rd degree consanguinity. She has 3 half-siblings form the father's previous marriage, all of whom are doing well. There is no history of neuropsychiatric morbidity in the family.

BIRTH AND DEVELOPMENT HISTORY

The antenatal period was reported to be uneventful. She was born by normal vaginal delivery at home at full term. There was no abnormal presentation or cord prolapse. She was of average size, birth weight was not known. The birth cry was normal and colour was pink. She had no feeding problems. She was breast fed till 3 years of age. She started having seizures at 8 months of age.

MILESTONES OF DEVELOPMENT

Delay was first noticed at 15 months of age.

Motor Milestones

Head Control : 3 months
Sitting : 15 months
Standing : 2 years
Walking : 3 years
Current level of functioning : can walk without support, can climb stairs up and down.

Speech and language development

Cooing : 6 years
Present level of functioning : no verbal or gestural communication, only looks at the object she wants.

Adaptive and play skills

She is not interested in playing with other children. She prefers solitary play. Her type of play is exploratory. She is not interested in any leisure time activities.

Socialisation

Social smile : not achieved
Recognition of mother : 5 years
She does not respond to her name, and she prefers to be with the mother.

Self help skills

Eating and drinking : independent when food is mixed and given.
Toileting : completely dependent
Dressing : completely dependent
Brushing : completely dependent
Bathing : completely dependent
Sense of modesty : not adequate

Schooling: She goes to special school, which she started at 4 years of age. She is regular to school and the medium of instruction is Tamil.

Comorbidity
She has epilepsy since 8 months of age.

BEHAVIORAL PROBLEMS
She has hyperactivity, self-injurious behavior like head banging, hand biting and hair pulling. She also has steorotyped, repetitive behavior like head rolling, body rocking, finger gazing, hand flapping and tapping on the nose.

MOOD
Blunted affect. She had poor eye contact, did not respond to namecall or to items of play.

PROVISIONAL DIAGNOSIS
Developmental delay
Seizure disorder
Overactivity associated with Mental Retardation

AIM OF PSYCHOLOGICAL TESTING
To assess her level of developmental functioning on the various domains and to make appropriate plans for early intervention.

TESTS ADMINISTERED
1) Vineland Social Maturity Scale
2) Gessell's Developmental Schedule

RATIONALE FOR TESTS ADMINISTERED
Vineland Social Maturity Scale: This scale measures the differential social capacities of individual. It provides an estimate of social age and social quotient.

Gessell's Development Schedule: This is a standardized procedure for observing and evaluating the course of development of a child at an early age. It assesses the appropriate development along five domains that is fine motor, gross motor, language, social skills and adaptive functioning.

BEHAVIOR OBSERVATION
The child's response to visual and auditory stimulus was inadequate. Her attention was difficult to arouse and sustain. Her fine and gross motor skills were fair. She mouthed all objects that were given for play.

TEST FINDINGS

On Vineland Social Maturity Scale

Self help general	: 1.43 years
Self help dressing	: not attained
Self help eating	: 2.35 years
Communication	: 0.25 years
Self direction	: not applicable for her age
Socialisation	: 0.30 years
Locomotion	: 1.75 years
Occupation	: 0.43 years

Total :1.20 years(maximum scores till last 10 could not be done)

On Gessell's Development Schedule

Adaptive	: 6 months
Gross motor	: 21 months
Fine motor	: 9 months
Language	: 2 months
Personal and social	: 9 months

Developmental age : 9.4 months

Developmental quotient : 11

DIAGNOSIS

Profound level of developmental delay
Seizure disorder
Overactivity associated with Mental Retardation

RECOMMENDATIONS

Parents were psychoeducated about the nature of the child's problem and the need for intervention. They were advised admission for improving self care, social, cognitive and play skills. Speech therapy and occupational therapy were also advised. Behavior management techniques were suggested.

CASE RECORD

NAME	: A.L.
AGE	: 17 YEARS
SEX	: MALE
OCCUPATION	: STUDENT
RELIGION	: HINDU
SOCIO-ECONOMIC STATUS	: MIDDLE CLASS
INFORMANTS	: PARENTS
RELIABILITY	: ADEQUATE

CHIEF COMPLAINTS

- Reduced concentration in studies
- Social withdrawal
- Irritability
- Preoccupation, predominantly increases sexual thoughts.

DURATION

2 years

MODE OF ONSET

Insidious

PRECIPITATING FACTORS

Nothing significant

HISTORY OF PRESENTING ILLNESS

Mr. A.L. was apparently well till 2 years ago when he was noticed to be preoccupied a lot of the times. His performance in school started deteriorating slowly. He complained of reduced concentration in studies and reduced memory. He was taken to a psychiatrist where he complained that he had increased sexual thoughts related to watching sexual content in movies. He also complained that he was unable to focus on his academics due to this. Sometimes his finger would get paralyzed due to this and he was unable to write or do any work. He had disturbed sleep and appetite secondary to these problems.

PAST HISTORY

There was no significant past history of neuropsychiatric morbidity.

FAMILY HISTORY

There was no significant family history of neuropsychiatric morbidity.

PERSONAL HISTORY

He was born of a normal delivery in hospital. His neonatal and early developmental period was uneventful. His developmental milestones were also normal. He was a student of 9^{th} standard and had been doing well academically till the onset of his illness. He had few friends in his neighbourhood and his interests included cricket and watching TV.

PREMORBID PERSONALITY

He was premorbidly described to be an easy child who was naughty, sometimes very absent minded. He was described as a friendly person.

PHYSICAL EXAMINATION

His vital signs were stable. CNS examination did not reveal any focal deficits. Other system examination was normal.

MENTAL STATUS EXAMINATION

He entered the room with his parents but asked that his parents leave the room as he wanted to talk to the therapist in private. His eye contact was poor and rapport was difficult to establish. His speech was rapid and disjointed. His thought process revealed poverty of content, tendency to repeat everything he said and obsessive thoughts of sexual nature. He denied any perceptual abnormalities. His affect was inappropriate and incongruent, he said he had disturbing thoughts but he was continuously laughing. His judgment was impaired and insight was poor.

DIFFERENTIAL DIAGNOSIS

- Paranoid Schizophrenia with Obsessive Compulsive symptoms
- Obsessive Compulsive Disorder
- Bipolar Affective Disorder

AIMS OF PSYCHOLOGICAL TESTING

To clarify the symptomatology and phenomenology.

To elicit the patient's thought process and psychopathology.

He had previously been on treatment for Obsessive Compulsive Disorder but had not shown much improvement.

TESTS ADMINISTERED AND RATIONALE FOR THE SAME

1) Bender Gestalt Test (BGT): to measure any visuo motor perceptual difficulty. It also helps to show any organicity.
2) Object sorting test: to assess any thought deviance.
3) Draw a Person Test (DAPT : a projective test that has been found useful in providing an understanding of the patient's personality as well as in ascertaining any psychopathology.
4) Sack' Sentence Completion Test (SSCT): for assessing conflict areas in the patient.
5) Thematic Apperception Test (TAT): to gain information about the level of psychopathology and to have an insight into the dominant traits and interpersonal relationships.
6) Rorshach's Ink Blot Test: projective test which is useful in measuring conscious and unconscious conflicts and drives, and is a viable diagnostic tool.

GENERAL OBSERVATION

He was cooperative and keen to do the tests. His attention could be aroused but could not be sustained for long. He appeared preoccupied in between the tests. His comprehension of the instructions was fairly good. His speech was soft but audible and his reaction time was increased. He was also anxious about his performance in the tests.

TEST FINDINGS

At the time of testing, his hypomanic symptoms were in partial remission since he was already on medication and hence were not clearly evident on the test findings.

The psychological testing revealed adequate reality orientation. Reaction time was normal. On the Rorshach protocol, the number of responses was high. Form level was variable. Minor detail responses were predominant. Content category was wide. There was no bizarre content in his responses. His organizational ability was poor. There were no pathognomonic signs like

contamination and confabulation. Popular responses were adequate in number.

He seemed to have significant anxiety when faced with threatening situations. His ability to perceive facts seemed to be poor. There was a need for perfection. It also showed conflicts in the area of peer relationships and attitudes towards teacher. He seemed to have excessive repetitive thoughts of sexual nature and significant guilt associated with this. He seemed to have high expectations for himself, probably not in line with his capability. He had conflicts regarding moral issues. The testing showed an inability to accept failure, along with indecisiveness about his plans. He seems to have a strong need for acceptance and recognition from his parents. There were no features to suggest a psychotic illness.

He seemed to have more of obsessional thoughts and distress related to that.There were no features to suggest a psychotic illness.

FINAL DIAGNOSIS

Obsessive Compulsive Disorder- predominantly Obsessions
Bipolar Affective Disorder- Currently hypomania.

MANAGEMENT

He was started on medications for both Obsessive Compulsive Disorder as well as Bipolar Affective Disorder. He was started on a combination of SSRIs under cover of Mood Stabiliser agent for control of his symptoms. The family was psychoeducated about the illness, course and prognosis. A step down of the curriculum was advised. It was also suggested to reduce pressure on academic performance and examination. It was also suggested to consider vocational rehabilitation in case problems persisted.

CASE RECORD

NAME	: MS. S.P.
AGE	: 16 YEARS
SEX	: FEMALE
OCCUPATION	: STUDENT
MARITAL STATUS	: SINGLE
INFORMANTS	: PARENTS
RELIABILITY	: RELIABLE, COMPLETE.

CHIEF COMPLAINTS

- Restlessness
- Abnormal behavior like shouting, irritability and disinhibition
- Disturbed sleep and appetite
- Seizures

DURATION

2 months

PRECIPITATING FACTOR

Episode of fever, vomiting and severe headache diagnosed as viral encephalitis.

HISTORY OF PRESENT ILLNESS

Ms. S.P. was apparently well till 2 months ago when she suddenly developed high grade fever with severe holocranial headache along with vomiting, which was followed by 3 episodes of generalized tonic clonic seizures. Since then she has been having multiple episodes of seizures. Also she was noticed to have abnormal behavior like shouting without any reason or provocation, anger outbursts and irritability. She was also noticed to have disinhibited behavior. She was noticed to be very restless, constantly pacing up and down and complaining of vague fear, occasionally muttering to herself and gesturing. Her sleep and appetite had markedly reduced. There was no history suggestive of mood disorder, anxiety or obsessive compulsive symptoms.

PAST HISTORY

There was no significant past history of neuropsychiatric morbidity.

FAMILY HISTORY

There was no family history of any neuropsychiatric morbidity.

PERSONAL HISTORY

She was a student in 11th standard, academically very good prior to the onset of illness.

PREMORBID PERSONALITY

She was known as a pleasant person, friendly and soft spoken.

PHYSICAL EXAMINATION

Her vital signs were stable. CNS examination did not reveal any focal deficits. Other systems examination was also normal.

MENTAL STATUS EXAMINATION

She was moderately built, adequately kempt, could make eye contact and maintain it. She was oriented to time, place and person. Her speech and language were good. Her thought process did not reveal any abnormality. She denied any perceptual abnormality. She was of average intelligence. Her judgement was intact, however her insight into the illness was partial.

AIM OF TESTING

Neuropsychological testing was done to assess her level of cognitive functioning and to suggest rehabilitative methods.

TESTS ADMINISTERED AND RATIONALE FOR THE SAME

1) Bender Gestalt Test (BGT): to check for visuo-motor coordination
2) PGI Memory Scale : to assess her immediate, recent and remote memory and new learning capacity.
3) Bhatia's Battery of Performance Test(shortened version)
4) NIMHANS Neuropsychological Battery: to test the patient's performance across all lobe functions.

GENERAL OBSERVATION

She came for the testing appropriately dressed and well groomed. She was alert and attentive to the surroundings. She was also enthusiastic to do the tests. However she had mild difficulty in persisting in the tasks for a prolonged period.

TEST FINDINGS

FRONTAL LOBE FUNCTIONS

Attention: spontaneous arousal is present, she occasionally gets distracted by irrelevant external stimuli.
On tests of visual scanning, trail making and number cancellation there was no significant impairment of attention.
Perseveration tests showed no abnormality. She could perform adequately on the continuous drawing test.
Her working memory (verbal) assessed on various tests showed moderate impairment.
On the Ideational fluency test, there was no impairment.
Design fluency; no impairment
Her visuo-spatial planning was fair, assessed on Bender Gestalt Test. There was no distortion, rotation or perseveration. There was no difficulty in organizational ability.
Performance on Maze test was fairly adequate.
Her expressive speech was good. She was audible and could express herself fluently.

TEMPORAL LOBE FUNCTIONS

Her visual integration ability as assessed on the Block Design test and Object Assembly test was fair. She showed difficulty with increasing complexity of tasks. Verbal learning and memory were impaired moderately.
Logical memory: intact,
Sentence registration: she had no difficulty with shorter sentences but had difficulty in recalling longer sentences.
Comprehension: she had no difficulty in following instructions. There was no need for repetition of instructions.
Visual learning was mildly impaired as assessed on the Rey Complex Design test and the Visual Retention Test.

PAREITAL LOBE FUNCTIONS

Visual spatial perception was good. There was no significant impairment.
Focal signs like agnosia or apraxia were not present.

MMSE score: 28/29

SUMMARY

Neuropsychological testing showed deficits across all lobes. However her recent memory and new learning capacity seems to be more affected.

MANAGEMENT

The family was psychoeducated about the nature and course of the problem. Suggestions were made regarding graded exposure back to school to establish a routine, reducing pressure on academic performance and examination. Suggestions were also made to improve her quality of life. Cognitive retraining methods to improve memory and attention were also suggested.